Supreme Court, U.S.
FILED
'99 183 JUL 27 1999
OFFICE OF THE CLERK

No.

IN THE

Supreme Court of the United States

MARY–LOUISE O'NEAL,

Petitioner,

v.

FHP, INC., LOMA LINDA FACULTY MEDICAL GROUP, INC. and BONNIE BARNES,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE CALIFORNIA SUPREME COURT

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Did the California Court of Appeal correctly determine that Medicare administrative remedies were required to be exhausted by the enrollee of a Medicare-qualified health maintenance organization: (1) Where the enrollee was seeking damages only under state tort law claims; (2) Where the damages claimed arose solely from a delay in the provision of Medicare-mandated benefits, but not an ultimate denial of such benefits; or (3) Where the wrongfully-withheld benefits were benefits supplemental to the Medicare-mandated benefits?

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Appendix C — Order Of The Supreme Court Of California For The Fourth Appellate District, Division Two Denying Petition For Review Dated And Filed April 28, 1999 ..... 17a

Petitioner Mary-Louise O'Neal respectfully prays that a writ of certiorari issue to review the judgment of the Supreme Court of the State of California filed on April 28, 1999, which became final on May 28, 1999. The Supreme Court denied review of the decision of the Court of Appeal of the State of California, Fourth Appellate District, Division Two, which was issued on February 5, 1999. The appellate court's decision held that the enrollee of a Medicare-qualified health maintenance organization is required to submit all her claims to Medicare's administrative review procedures pursuant to 42 U.S.C.A. § 1395mm, even where those claims are solely for state law tort damages, where the injuries for which damage is claimed arose from the delay in provision of Medicare-mandated benefits which were ultimately provided and where the delay and denial related to benefits provided under the HMO's plan which were supplemental to the Medicare-mandated benefits. The California Supreme Court refused to review the decision of the appellate court and that decision is contrary to every federal case – both appellate court level and district court level – decided in this country. The California state court's decision has the practical effect of stripping every California Medicare-HMO member of their right to state tort remedies in abrogation of Congress's intent to protect Medicare enrollees.

OPINIONS BELOW

The unpublished April 28, 1999 order of the Supreme Court of the State of California in this matter which gives rise to this petition is entitled *Mary-Louise O'Neal v. FHP, Inc., et al.* A copy of that order is reprinted in Appendix C hereto. The decision of the Court of Appeal of the State of California, Fourth Appellate District, Division Two, review of which was denied in the Supreme Court's order, is

reprinted in Appendix A. The judgment of dismissal of the Superior Court of the State of California from which the appeal to the appellate court was taken is reprinted in Appendix B.

STATEMENT OF JURISDICTION

On April 28, 1999, the Supreme Court of the State of California denied review of the decision rendered by the Court of Appeal of the State of California, Fourth Appellate District, Division Two.

Approximately 4 million of California's senior citizens are enrolled in Medicare. Of those, approximately 1.5 million have elected to receive their Medicare benefits through enrollment in managed care plans or health maintenance organizations ("HMOs"). (Data as of March, 1997, see http:\\www.medicaid.com\ medicare\mpsct1.htm.) HMOs are allowed to provide Medicare benefits to qualified senior citizens as the result of federal legislation included in Part D of the Medicare Act. (42 U.S.C. § 1395mm.)

Under the Medicare Act, a claim for benefits against an HMO is subject to Medicare's administrative review process. But several federal court cases, construing and applying the Medicare Act, have held that tort claims arising from an HMO's failure to provide benefits under its contract with its senior-care members are not subject to Medicare's administrative review provisions. Those courts, including both the Fourth and Ninth Circuit Courts of Appeals, examined both the language and history of the Medicare Act, its administrative review provisions and the specific portion of the Act dealing with HMO contracts and concluded that the administrative review provisions were explicitly intended

to address only the "quite minor matters" relating to "amount determinations" for benefits that were denied and was never intended to apply to state law-based tort claims for damages arising from a wrongful denial of benefits.[1]

Despite the existence of that extensive federal law construing a federal statute, the Court of Appeal of the State of California, Sixth District held in *Redmond v. Secure Horizons, Pacificare, Inc.* (1997) 60 Cal. App. 4th 96, 70 Cal. Rptr. 2d 174 that all claims, irrespective of whether they are claims for benefits or tort claims, must be subjected to the Medicare administrative review process. As discussed in detail below, the *Redmond* court not only misused ellipses and misquoted a Medicare statute in order to support its erroneous conclusion, the decision also conflicts with the federal authority construing and applying this federal legislation, the decision conflicts with the regulations promulgated by the Department of Health and Human Services for implementation of the Medicare Act provisions relating to HMOs and, additionally, is internally inconsistent and illogical. In the present case, the Fourth District Court of Appeal, Division 2 also elected to ignore the federal cases construing this federal law and to instead follow the *Redmond* court's misplaced analysis.

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1. Those cases include: *Ardary v. Aetna Health Plans of California Inc.*, 98 F.3d 496 (9th Cir. 1996), *cert. denied*, 520 U.S. 1251, 117 S. Ct. 2408; *Talbot v. Lucy Corr Nursing Home*, 118 F.3d 215, n.1 (4th Cir. 1997); *Wartenberg v. Aetna U.S. Healthcare, Inc.*, 2 F. Supp. 2d 273; *Berman v. Abington Radiology Associates, Inc.* 1997 WL 534804 (E.D. Pa. 1997); *Zamora-Quezada v Health Texas*, 34 F. Supp. 2d 433 (W.D. Tex. 1998); *Winkler v. Interim Health Services Inc.*, 26 F. Supp. 2d 1026 (M.D. Tenn. 1999); and *Plocica v. NYLCARE of Texas, Inc.*, 43 F. Supp. 2d 658 (N.D. Tex. 1999).

Despite the clear error in the appellate court's decision and despite the overwhelming importance of the issue presented, the California Supreme Court refused to review the appellate court's decision – a decision which misapplies federal law and conflicts with every federal court case on the issue. Accordingly, jurisdiction of this Court to review the decision of the Supreme Court of the State of California is invoked under 28 U.S.C.A. § 1257 and Rules of the United States Supreme Court, Rule 10(b) and (c).

STATUTES INVOLVED

This case involves the interpretation of 42 U.S.C.A. § 1395mm(c)(5)(B), which provides as follows:

> A member enrolled with an eligible organization under this section who is dissatisfied by reason of his failure to receive any health service to which he believes he is entitled and at no greater charge than he believes he is required to pay is entitled, if the amount in controversy is $100 or more, to a hearing before the Secretary to the same extent as is provided in section 405(b) of this title, and in any such hearing the Secretary shall make the eligible organization a party. If the amount in controversy is $1,000 or more, the individual or eligible organization shall, upon notifying the other party, be entitled to judicial review of the Secretary's final decision as provided in section 405(g) of this title, and both the individual and the eligible organization shall be entitled to be parties to that judicial review. In applying sections 405(b) and 405(g) of this title as provided in this subparagraph, and in applying section 405(l) of

this title thereto, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively.

STATEMENT OF THE CASE

In January 1995, MARY-LOUISE O'NEAL ("MARY-LOUISE"), a charming, active and independent 90-year-old lady, enrolled in FHP's senior-care health benefits plan. [Clerk's Transcript[2] 222, ¶ 1.] A year later, when she suffered a stroke while playing bingo at the "Old Timers" club, she became a statistic in the managed care system. [*Id.*] She became a victim of a deliberate and widespread program adopted and implemented by FHP to wrongfully and illegitimately minimize its members' use of skilled nursing facilities and rehabilitation benefits. [*Id.*]

After MARY-LOUISE's acute care needs resulting from the stroke had been addressed, FHP authorized transfer of MARY-LOUISE to a skilled nursing facility for rehabilitation. [*Id.*, ¶ 2.] Consistent with a pattern of conduct displayed in many other cases, however, FHP "evaluated" MARY-LOUISE within days of the transfer and determined that she had "plateaued" – i.e., that the rehabilitation therapy had done all for her that could be accomplished – and that she should essentially be "warehoused" in a convalescent hospital until she died. [*Id.*]

Fortunately for MARY-LOUISE, her son, Enos Doyle, refused to accept that determination, knowing full well that

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2. Hereinafter, "CT."

his mother was in no shape to survive a convalescent hospital without continued skilled nursing care and further rehabilitation. [*Id.*, ¶ 3.] Mr. Doyle objected to the transfer and was finally able to convince FHP that further rehabilitation would not only be helpful, but was absolutely necessary. [*Id.*] But FHP was not convinced for long. The same pattern repeated itself over and over again: FHP would "evaluate" MARY-LOUISE and make a determination that she did not need further rehabilitation, Mr. Doyle would protest, FHP would retract its denial of further rehabilitation benefits and MARY-LOUISE would be allowed to eke out a few more days of the rehabilitation care she medically needed and was contractually entitled to have. [CT 222-223, ¶ 4] But the physical strain and emotional trauma MARY-LOUISE suffered as a result of this constant delay in receipt of her needed physical therapy and rehabilitative care slowed and impaired her physical recovery and deprived her of months of health and well-being. [*Id.*]

FHP's effort to impede MARY-LOUISE's access to rehabilitation was a calculated business decision based on its own financial interest. [*Id.*, ¶ 5.] Most simply, FHP denies rehabilitation benefits because, due to the member's age and lack of expected longevity, FHP thinks the member is simply not "worth" rehabilitating. [*Id.*, ¶ 6.]

The complaint in this action alleges clearly and unequivocally the factual basis demonstrating that MARY-LOUISE's claims are not subject to the administrative review requirements set forth in the Medicare Act in the first instance. [CT 228-230, ¶¶ 22-28.] For example, even under the Medicare Act and the regulatory provisions promulgated pursuant to it, an HMO may agree to provide care in excess of Medicare's specified minimum requirements and those

supplemental benefits are expressly not subject to Medicare's administrative review process. Similarly, a claim based on the delay in the provision of benefits, where the benefits were ultimately provided by the HMO, is also expressly excluded from the administrative review process under the applicable Medicare provisions. MARY-LOUISE's complaint alleges both of those circumstances, thus precluding the application of any administrative review process in the first place.

Moreover, the complaint also alleges – specifically and clearly – the facts demonstrating that, even if Medicare's administrative review provisions otherwise applied to MARY-LOUISE's claim for benefits, they patently do not apply to her tort claims for the physical and emotional injuries suffered as the result in the delay in the provision of those benefits.

Defendants demurred to MARY-LOUISE's complaint, contending that her claims were, in fact, subject to Medicare's administrative review process. MARY-LOUISE opposed that demurrer, citing to both California and federal authority demonstrating that her claims were not subject to Medicare administrative review. Despite the inapplicability of the Medicare review provisions to the claims in this case, the trial court sustained defendants' demurrers, without leave to amend, and dismissed the case on the basis that MARY-LOUISE had failed to exhaust her administrative remedies. [Appendix B; CT 552-556; Reporter's Transcript 12:4-7.] The appellate court affirmed that ruling [Appendix A] and the California Supreme Court denied review. [Appendix C.]

REASONS FOR GRANTING THE WRIT

The decisions in *Redmond* and this case impact and affect the rights of nearly one and one-half million California senior citizens and effectively strip them of their ability to hold HMOs accountable for the injuries inflicted on them when their HMOs wrongfully refuse to provide benefits. Obviously, this issue is of grave importance and is one that substantially – and negatively – impacts the rights of all Medicare HMO members to enforce their state law remedies. Since the decisions in *Redmond* and in this case not only conflict with the federal court cases construing the federal statutory scheme and are, in and of themselves, inherently illogical, and since this is an issue of ever-growing concern to the bench and the bar, review should be granted in order to protect all Medicare enrollees and to conform California's application of law in this context to the federal cases and the controlling federal statutes.

I.

THE CALIFORNIA COURT INCORRECTLY INTERPRETED A FEDERAL STATUTE IN DETERMINING THAT PERSONAL INJURY CLAIMS ARISING FROM A MEDICARE HMO'S WRONGFUL REFUSAL OF, OR DELAY IN PROVIDING, BENEFITS ARE SUBJECT TO MEDICARE'S ADMINISTRATIVE REVIEW PROVISIONS.

A. Background Regarding Medicare HMOs

Congress established a program in which the Department of Health and Human Services, through its administrative agency, the Health Care Financing Administration

("HCFA"), contracts with various HMOs to provide medical care to Medicare-eligible California senior and disabled citizens. [CT 225, ¶ 14.] (*See also* 42 U.S.C. § 1395mm; *Solorzano v. Superior Court (FHP, Inc.)*, 10 Cal. App. 4th 1135, 13 Cal. Rptr. 2d 161 (1993).)

Under that program, the Department of Health and Human Services pays to the contracting HMO 95% of the statistically-calculated average expenditure expected in the particular geographic area for each Medicare-eligible citizen. [CT 225-226, ¶ 15.] (*Id.*) In Southern California, the average expenditure calculated by the Department of Labor to be paid for eligible treatment, over the lifetime of a Medicare eligible person, is approximately $600 per month. [*Id.*]

This statistically-calculated amount necessarily encompasses the amount Medicare expects to pay for the anticipated medical treatment for each Medicare recipient over their lifetime, including both periods during which the recipient is well and during periods when the recipient suffers extensive medical problems, including cancer, heart attacks, strokes and the like. [CT 226, ¶ 16.]

Thus, for each Medicare enrollee, FHP is paid 95% of approximately $600 (*i.e.*, $570), whether the member is ill or not and whether the member is provided treatment or not. [*Id.*, ¶ 17.] The contracting HMOs are also required to permit the members to disenroll at any time, with the disenrollment effective on the first of the month following the request for disenrollment. [*Id.*] Upon disenrollment, the Medicare eligible recipient may either resume the standard Medicare entitlement or may enroll with another contracting HMO. [*Id.*]

Generally, an HMO senior-care member whose treatment requests are denied is required under 42 U.S.C. § 1395mm(c)(5)(B) to utilize the Medicare administrative review process set forth in 42 U.S.C. § 405(g).

But in two specific situations delineated by the regulations pursuant to the statute, a senior-care member who believes their treatment request has been wrongfully denied need not seek administrative review of that benefits decision through the standard Medicare claim review process: (1) Where the services were, in fact, furnished and the enrollee has no further obligation for payment; and (2) Where the services as to which there is a dispute are included in an optional supplemental plan providing coverage over and above the standard Medicare minimum requirements. (42 C.F.R. § 417.606(b).)

Additionally, several federal courts, including both the Fourth and Ninth Circuit Courts of Appeals, have determined that where the HMO senior-care member seeks tort damages against the HMO arising from the HMO's failure to provide benefits, those tort claims are not subject to administrative review. (*Ardary v. Aetna Health Plans*, 98 F.3d 496 (9th Cir. 1996), *cert. denied*, 520 U.S. 1251, 117 S. Ct. 2408, 138 L. Ed. 2d 174, 65 U.S.L.W. 3798 (1997); *Talbot v. Lucy Corr Nursing Home*, 118 F.3d 215, n.1 (4th Cir. 1997); *Berman v. Abington Radiology Associates, Inc.*, 1997 WL 534804 (E.D. Pa. 1997); *Wartenberg v. Aetna U.S. Healthcare, Inc.*, 2 F. Supp. 2d 273 (E.D. N.Y. 1998); *Zamora-Quezada v Health Texas*, 34 F. Supp. 2d 433 (W.D. Tex. 1998); *Winkler v. Interim Health Services Inc.*, 26 F. Supp. 2d 1026 (M.D. Tenn. 1999); and *Plocica v. NYLCARE of Texas, Inc.*, 43 F. Supp. 2d 658 (N.D. Tex. 1999.)

Two other California appellate court decisions are also in accord with that conclusion. (*Solorzano v. Superior Court (FHP, Inc.)*, 10 Cal. App. 4th 1135, 13 Cal. Rptr. 2d 161 (1993); *Podolsky v. First Healthcare Corp.*, 50 Cal. App. 4th 632 (1996).)

Each of those exceptions apply in this case:

- MARY-LOUISE's primary claim is for the personal injuries suffered by her as the result of defendants' unreasonable refusal to timely and consistently provide the benefits promised in defendants' contract with her.

- Over the course of MARY-LOUISE's treatment for recovery from her stroke, and only after extensive protest of FHP's decisions and submission of medical proof of the continuing need for rehabilitation was MARY-LOUISE able to obtain the rehabilitation care she needed. [CT 228, ¶ 22.] Thus, the bulk of the "benefits" owed to her under the FHP senior-care plan was ultimately provided. [*Id.*] In the process, however, FHP's unreasonable interim denials still resulted in financial damage and emotional distress damages which are recoverable in this action, but which are not subject to the Medicare review process.

- And, as specifically alleged in the operative complaint, "the treatment sought by plaintiff constituted benefits provided under the FHP plan but which were not provided under or required by Medicare [but] were promised by FHP in excess of the Medicare requirements." [CT 229, ¶ 27; emphasis added.] Thus, under 42 C.F.R. § 417.606(b)(2), administrative review of those decisions was not required.

Despite the fact that the claims at issue in this action do not fall within any Medicare administrative review requirement, and despite the fact that the federal courts have concluded that no administrative review requirement applies to a claim for tort damages – even where it arises from a denial of a benefit that would otherwise be subject to the administrative review process – the California Court of Appeal in this case relied on a wrongly-decided case issued by a different district of the California Court of Appeal and erroneously concluded that MARY-LOUISE's claims are subject to administrative review. That conclusion, however, is patently wrong and certiorari is desperately needed in order to assure that California's senior citizens' state law tort remedies are not improperly abrogated by an inappropriate application of Medicare's administrative review provisions. Indeed, a number of other similar cases – presenting these same issues – are presently working their way through the California courts and direction is needed from this Court on these issues in order to assure that every Medicare beneficiary's rights are protected.

B. The California Court Of Appeal Wrongfully Concluded That A Personal Injury Claim Arising From The Denial Of Medicare Benefits Is Subject To Medicare's Administrative Review Requirements

As set forth in section D, below, MARY-LOUISE's benefit claims are not subject to Medicare's administrative review provisions in the first instance because they are benefits which expressly fall outside the parameters for administrative review. But even if MARY-LOUISE's underlying benefit claims were, in fact, subject to Medicare's administrative review provisions, the appellate court's conclusion that she had to exhaust those administrative

review requirements prior to bringing her personal injury claims is wrong. Indeed, all the federal cases that have dealt with this issue are in accord: Tort claims do not fall within Medicare's administrative review requirements. Only one other case, a California state court case, has reached a contrary conclusion and, as discussed below, that case was wrongly decided.

The issue of whether a tort claim arising from a benefit denial by a Medicare HMO must be submitted to the Medicare administrative review process was first decided by the Ninth Circuit Court of Appeals in *Ardary v. Aetna Health Plans*, 98 F.3d 496 (9th Cir. 1996), *cert. denied*, 520 U.S. 1251, 117 S. Ct. 2408, 138 L. Ed. 2d 174, 65 U.S.L.W. 3798 (1997).

In *Ardary*, the plaintiffs' wife and mother, Cynthia Ardary, enrolled in a senior care plan just like the one MARY-LOUISE was in at the time her claims arose. Mrs. Ardary suffered a heart attack and was transported to the small, local community hospital in Big Bear. The hospital there was simply unequipped to deal with her extremely serious condition, and the emergency room doctor requested approval from Aetna to have Mrs. Ardary airlifted to Loma Linda University Hospital. Despite knowing that the airlift transfer to Loma Linda was Mrs. Ardary's only chance of survival, Aetna refused the request. Mrs. Ardary died at Big Bear several hours later.

Mrs. Ardary's husband and children sued Aetna and its doctors group not only for wrongful death, but also for negligent and intentional infliction of emotional distress and fraud. After removing the action to federal court on the grounds that federal question jurisdiction existed under the

Medicare Act, Aetna then sought to dismiss the Ardarys' action on the basis that it was precluded by the failure to exhaust the administrative remedy provisions of the Medicare Act. The Ninth Circuit flatly rejected that argument, holding instead that state law tort claims against a private Medicare provider are not preempted by the Medicare Act, and, thus, that Medicare's administrative remedies need not be exhausted before those claims can be pursued in state court. The same result is mandated here.

The Ninth Circuit's discussion in *Ardary* centered on the language of the Medicare statute. That statute requires that claims "arising under" the Medicare Act be submitted to the administrative review process provided in the Act. Aetna argued there, as defendants did here, that the tort claims were subject to those administrative review provisions because all the damage claims "related to" the original denial of Medicare benefits. The Ninth Circuit rejected that analysis as an "over-inclusive reading of the 'arising under' language" of the statute. (*Ardary*, 98 F.3d at 499.) The court concluded that even applying the rule in *Heckler v. Ringer*, 466 U.S. 602, 104 S. Ct. 2013, 80 L. Ed. 2d 622 (1984), and its progeny to the issue of whether state law tort claims are subject to Medicare's administrative review provisions inevitably results in the conclusion that they are not. This is because those claims necessarily "arise under" ***state common law rights***, *not* Medicare rights and thus did not fulfill the *Heckler v. Ringer* requirement that the complaint " 'include any claims in which "*both* the ***standing*** and *the substantive basis* for the presentation" of the claims' is the Act." (*Id.*, emphasis added.)

The *Ardary* court also distinguished the federal cases cited by defendants and relied on by the appellate court here,

rejecting the notion that the tort claims were "at bottom" claims for benefits or that the tort claims were "inextricably intertwined" with the contractual benefit claims:

> Contrary to Aetna and Arrowest's assertions, *Bodimetric* should not be taken to imply that private Medicare providers and their representatives cannot be held responsible in their individual capacity for tortious acts committed in the context of the denial of Medicare benefits. *The removal of the right to sue the private Medicare provider for its torts would result in an inequitable and substantial dilution of the rights of patients*. Aetna and Arrowest's argument that the claims are "inextricably intertwined" with the claim that Cynthia was improperly denied benefits simply misapplies *Ringer* and *Bodimetric* on these facts.

Ardary, 98 F.3d at 501 (emphasis added).

The *Ardary* court's analysis also considered the issue of whether the underlying legislative intent of the Medicare statutes somehow supported the claim that significant state law rights were intended by Congress to be subsumed within Medicare's administrative review process. Concluding that it did not, the *Ardary* court quoted from this Court's decision in *Bowen v. Michigan Academy of Family Physicians*, 476 U.S. 667, 106 S. Ct. 2133, 90 L. Ed. 2d 623 (1986) which, in turn, quoted from the remarks of Sen. Bennett in passing the legislation:

> [T]he "legislative history of both the statute establishing the Medicare program and the 1972

> amendments thereto ***provides specific evidence of Congress' intent to foreclose review only of "amount determinations" — i.e., those "quite minor matters,"*** . . . remitted finally and exclusively to adjudication by private insurance carriers in a "fair hearing."

Ardary, 98 F.3d at 501 (emphasis added).

The explicit statement of congressional intent that only review of amount determinations were intended to be foreclosed by Medicare's administrative review provisions further requires the conclusion that those provisions do not apply in this case – or in any case asserting personal injury claims – since the action does not challenge any "amount determination." Rather, a personal injury claimant seeks the right to assert substantial and significant state law rights which, based on that congressional intent, cannot be preempted.

Further, the Ninth Circuit noted, "the state law claims are not 'inextricably intertwined' with the denial of benefits . . . because the Ardarys are at bottom not seeking to recover benefits." (*Ardary*, 98 F.3d at 500; emphasis added.) Here, too, a personal injury claimant, such as MARY-LOUISE, is, at bottom, not seeking to recover Medicare benefits.

The *Ardary* court also noted that in that case, administrative review would be useless because the retroactive payment of benefits after exhaustion of the administrative remedies would not remedy the injury. Similarly, an HMO cannot go back in time and undo the physical injury and emotional harm caused by its callous denial or delay of benefits it wrongfully withheld.

After concluding that the state law claims "do not 'arise under' the Act," the Ninth Circuit then considered the issue of whether, given that, any federal jurisdiction existed sufficient to avoid remand of the action – and concluded that none did:

> The Medicare statutes, as applied to an HMO contract, do not, of course, contain a preemption provision. . . . Because we hold that the Ardarys' state law claims do not "arise under" the Medicare Act, we must conclude that the action was improperly removed to federal court. *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 66, 107 S.Ct. 1542, 1547-48, 95 L.Ed.2d 55 (1987).

Id., 98 F.3d at 501-502.

The Ninth Circuit then ordered the action remanded to state court because the claims were not subject to Medicare administrative review requirements and there was, therefore, no federal question jurisdiction.

Since the decision in *Ardary* was issued, every federal court which has considered the issue in a published opinion has concurred in the *Ardary* court's analysis and held that personal injury or tort claims arising from the wrongful denial or delay in the provision of benefits to a Medicare HMO member are not subject to Medicare's administrative review process:

- *Talbot v. Lucy Corr Nursing Home*, 118 F.3d 215 (4th Cir. 1997). In *Talbot*, the court held that exhaustion of federal Medicare remedies is not

required where the Medicare member is seeking damages resulting from a violation of the resident rights provisions of federal Medicare law. (*Talbot*, n.1.)

- *Berman v. Abington Radiology Associates, Inc.*, 1997 WL 534804 (E.D. Pa. 1997). In *Berman*, the plaintiff sued her physicians, their medical group and her Medicare HMO for negligence. Following this Court's test in *Heckler v. Ringer*, the *Berman* court found that state common law, not the Medicare Act, provided the standing and substantive basis for plaintiff's claims and that plaintiff's claim was not, therefore, inextricably intertwined with a claim for Medicare benefits and that the action did not, therefore, "arise under" the Medicare Act.

- *Wartenberg v. Aetna U.S. Healthcare, Inc.*, 2 F. Supp. 2d 273 (E.D.N.Y. 1998). As noted by the Wartenberg court:

> although the Supreme Court read the "arising under" language of the Act broadly, it also explicitly recognized that not all cases are appropriate for the initial exhaustion of the administrative remedies provided under the Act. See *Heckler v. Ringer*, 466 U.S. at 618. The Court noted that if a claim was wholly collateral to a claim for benefits, and if the plaintiff made a colorable showing that his injury could not be remedied by the retroactive payment of benefits, administrative remedies would not be appropriate for such a case. . . . Furthermore, plaintiff's claims are collateral to a claim for benefits, since the standing

of the plaintiff's claims is rooted in state law causes of action, and not the Medicare Act, as was the case in Heckler.

- *Zamora-Quezada v. Health Texas*, 34 F. Supp. 2d 433 (W.D. Tex. 1998). In finding that the standing and substantive basis for the patients' claims under the Americans With Disabilities Act against their Medicare HMOs was not the Medicare Act, this court commented on the *Ardary* case as instructive.

- *Plocica v. NYLCARE of Texas, Inc.*, 43 F. Supp. 2d 658 (N.D. Tex. 1999.) Here, as in *Ardary* and *Wartenberg*, the court found that the state law-based tort claims made by a Medicare enrollee against a Medicare HMO do not meet the *Heckler* test and do not implicate Medicare's administrative review provisions.

- *Winkler v. Interim Health Services Inc.*, 26 F. Supp. 2d 1026 (M.D. Tenn. 1999).

C. The *Redmond* Decision Was Erroneously Decided And, Because It Is Leading Other Courts Astray, Certiorari Should Be Granted To Correct The Law As Misapplied By The California Courts

In ruling that MARY-LOUISE's claims were all preempted by Medicare's administrative review provisions, the appellate court in this case relied on and quoted extensively from the decision in *Redmond v. Secure Horizons, Pacificare, Inc.*, 60 Cal. App. 4th 96, 70 Cal. Rptr. 2d 174 (1997). In Redmond, the Sixth District Court of Appeal concluded that the plaintiff's tort claims against a

Medicare HMO were preempted by Medicare's administrative review provisions and that those provisions precluded the state law tort claims. But the appellate court's reliance on *Redmond* was misplaced, both because *Redmond* does not apply factually and because *Redmond* is poorly reasoned and wrongly decided. Indeed, the *Redmond* court's analysis is defective on several different levels.

1. *The Redmond court misquoted the applicable statutory provisions.*

In an appalling misuse of ellipses, the *Redmond* court misquoted the applicable statutory language from the Medicare statute in order to support its erroneous conclusion that the Medicare administrative review process subsumed the tort claims at issue in the case before it. Even more appalling, the appellate court in this case adopted and perpetrated the *Redmond* court's misquotation – even after the error was pointed out to the appellate court at oral argument in this case.

In *Redmond*, the court quoted from 42 U.S.C. § 1395ff, subdivision (a), as follows:

> "The determination of whether an individual is entitled to benefits . . . and the determination of the amount of benefits . . . , and any other determination with respect to a claim for benefits . . . shall be made by the Secretary [of Health & Human Services] in accordance with regulations prescribed by him."

The problem is, when that section is reviewed in its entirety, the material contained in the excised portion of the

quoted statute reveals that ***section 1395ff does not apply to claims made against Medicare HMOs***. The excised references, in fact, specifically provide that section 1395ff applies *only* to claims made under Subpart A and Subpart B of the Medicare Act. The provisions that establish and regulate Medicare HMOs, however, appear in ***Subpart*** *D* of the Act, not Subparts A or B. Thus, by its creative – and illegitimate – use of ellipses, the *Redmond* court created language facially supporting its conclusion, but created that language out of a statutory provision which actually defeats its conclusion.

2. *The Redmond court ignored the fact that consequential damages cannot be remediated under the Medicare review process.*

In addition to misquoting the Medicare statutes in order to illegitimately support its conclusion, and in addition to unjustifiably rejecting the analysis of the *Ardary* court on the issue, the *Redmond* court also ignored the fact, acknowledged in both *Ardary* and *Wartenberg*, that the Medicare administrative review process can do nothing more than determine whether the benefits should have been provided – there is no mechanism for awarding damages caused by the wrongful denial of benefits.

The *Redmond* court cited to 42 U.S.C. § 1395mm(i)(6) as justification for requiring that the tort claims proceed to the administrative review process, in the apparent belief that the section somehow authorizes an award of tort damages by the Secretary of Health and Human Services. (*Redmond*, 60 Cal. App. 4th at 100-101, 70 Cal. Rptr. 2d at 176.) But the court's reliance on that section was wholly misplaced. Section 1395mm(i)(6) provides only for imposition of civil

money penalties, not damages. Moreover, those penalties are paid solely to the Secretary. Thus, that section cannot compensate a member for consequential damages caused by the HMO's misconduct.

The *Redmond* court attempted to distinguish itself from *Ardary* by asserting that, in *Ardary*, the Ninth Circuit concluded that the administrative remedies did not have to be exhausted because the member had died and payment would not remediate the harm. (*Redmond*, 60 Cal. App. 4th at 103-104, 70 Cal. Rptr. at 178.) The *Redmond* court reasoned, then, that where a member was merely seeking reimbursement of expenses incurred by the member in obtaining the denied treatment elsewhere, the reimbursement itself would suffice as remediation.

But that simplistic analysis overlooks the consequential harm – financial, physical and emotional – that results from an HMO's wrongful refusal to provide promised benefits. Assume, for example, that the member needed care that cost $150,000 and had to mortgage their home to obtain that care when the HMO wrongfully denied payment. Later reimbursement after administrative review would not remediate the financial harm suffered by the insured in incurring the costs of obtaining the loan or in making the interest payments made on it. Nor can the later reimbursement remediate the emotional toll such a situation creates. And if there is some adverse impact on the member's medical condition due to the delay in receiving the treatment, later reimbursement for the cost of the treatment itself cannot remediate that harm either.

And forcing the plaintiff in *Redmond* to administrative review in that case was a pointless exercise, since the HMO

had already reimbursed the plaintiff for the treatment expenses even before suit was filed and the plaintiff was suing solely for the recovery of consequential damages for injuries proximately caused by the wrongful initial denial and delay in providing the benefits. Since the HMO had already acknowledged its obligation for payment of the benefits, and had paid them, and since the administrative review process cannot compensate a member for the consequential damages caused by the HMO's wrongful conduct, there was, in reality, nothing to be reviewed in the administrative process.

To that extent, the *Redmond* decision is not only illogical and nonsensical, it represents an enormous waste of resources for the plaintiff, the defendant and the administrative review process as a whole.

3. The Redmond court failed to conduct an adequate preemption analysis.

The *Redmond* court's conclusion that Congress intended that the Medicare review process preempt any and all state law tort claims in any way related to the underlying Medicare claim is patently wrong in light of the congressional intent analysis of both *Ardary* and *Wartenberg*. In fact, the *Redmond* court failed to conduct any adequate preemption analysis in the first instance. But, as noted above, the *Solorzano* court did conduct that analysis and its decision demonstrates the fundamental errors in reasoning committed by the *Redmond* court.

Moreover, if Congress intended to usurp the state's police power to regulate the health and welfare issues relating to its citizens, it certainly knew how to do so, since it did just that in the context of the Employee Retirement Income Security Act, 29 U.S.C. § 1001, *et seq.* ("ERISA"). Comparing the

preemption language of ERISA, the Federal Employee Hospital Benefits Act ("FEHBA"), 5 U.S.C. § 8902(m)(1), and the Medicare statute demonstrates that Congress never intended to preempt state law tort claims by subjecting them to Medicare's administrative review process:

ERISA's preemption language is very broad: ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." (29 U.S.C. § 1144(a); emphasis added.)

Similarly, the language in the FEHBA statute provides that FEHBA "shall supersede and preempt any State or local law . . . to the extent inconsistent with such contractual provisions." (5 U.S.C. § 8902(m)(1); emphasis added.)

In contrast, under Medicare, the statute merely provides that "[a]ny individual, after any final decision of the Commissioner of Social Security . . . may obtain review of such decision by a civil action. . . . The court shall have the power to enter . . . a judgment affirming, modifying, or reversing the decision . . ." (42 U.S.C. § 405(g).)

Obviously, the complete preemption of "any and all State" laws under ERISA and FEHBA cannot compare to the very limited preemption language of Medicare's administrative review provisions. Nowhere in the Social Security Act or in the Medicare Act, as it applies to Medicare HMOs under section 1395mm, did Congress even implicitly attempt to preclude tort actions based on a Medicare HMO's wrongful conduct.

As concluded by the *Ardary* court:

> We find nothing in the legislative history [of the Medicare Act] to suggest that the Act was designed to abolish all state remedies which might exist against a private Medicare provider for torts committed during its administration of Medicare benefits pursuant to a contract with HCFA.

Ardary, 98 F.3d at 501.

And, in fact, preemption of tort claims under Medicare's administrative review process would undermine and defeat Congress's intent in enacting the Medicare statutes. In contrast to the situation in ERISA – where one of the primary goals was to establish a consistent regulatory framework in order to preserve the availability of plan funds – the Medicare Act's fundamental purpose is to assure that America's aged and disabled are provided with a minimum level of medical care. (*Massachusetts Medical Soc. v. Dukakis*, 815 F.2d 790, 794 (1st Cir. 1987) [the basic purpose of the Medicare Act is "to insure adequate medical care for the elderly"].)

Obviously, imposing tort liability on an HMO which wrongfully refuses to authorize treatment or care to which the member is entitled under Medicare and/or the member's contract with the HMO will not discourage or hamper the HMO's vigilance in assuring that appropriate care is provided as required under Medicare. On the contrary, potential liability for such damages will incentivize an HMO to provide the appropriate and proper level of promised benefits – and will assure that Congress's intent is fulfilled. But precluding a Medicare-HMO enrollee from obtaining consequential damages for the HMO's tortious wrongs by

forcing those claims to an administrative review process which cannot award damages for those injuries would encourage unwarranted denials of benefits – a result in direct conflict with Congress's intent.

The *Redmond* court unjustifiably ignored those facts and rendered a decision that is illogical and erroneous. And the appellate court in this case improperly followed the *Redmond* court's lead.

D. The Appellate Court Erroneously Invoked Medicare's Administrative Review Provisions As To Benefits Which Do Not Fall Within The Parameters Of Medicare's Administrative Review Provisions In The First Instance

In addition to the fact that MARY-LOUISE's tort-based damage claims are not subject to Medicare review requirements in any event, the appellate court's determination in this case is even more ominous given the fact that, even under Medicare's own provisions, the benefits MARY-LOUISE was seeking from FHP are not subject to Medicare's administrative review provisions in the first instance.

The regulations governing Medicare's administrative review process, as it applies to HMO's is set forth in 42 C.F.R. § 417.600. Under those provisions an "organization determination" is final unless reconsidered or appealed pursuant to sections 417.614 through 417.626, which embody the Medicare administrative review process to the extent it applies to HMOs. (42 C.F.R. § 417.612.) But a claim decision that does not fall within the definition of an organization determination is not subject to the administrative review provisions. (42 C.F.R. § 417.606(c).)

Thus, the determination of whether a claim for benefits is subject to the administrative review procedures turns on whether it is an "organization determination." In 42 C.F.R. § 417.606(b), the regulations specify what determinations are not considered to be "organization determinations:"

> (b) Actions that are not organization determinations. The following are not organization determinations for purposes of this subpart:
>
> > (1) A determination regarding services that were furnished by the HMO or CMP, either directly or under arrangement, for which the enrollee has no further obligation for payment.
> >
> > (2) A determination regarding services included in an optional supplemental plan (see § 417.440(b)(2)).

Both of the "non-organization determination" elements apply to the underlying claims in this case and preclude application of the administrative review provisions. First, the complaint nowhere claims that rehabilitation care MARY-LOUISE needed was not ultimately provided. Nor is there any allegation that MARY-LOUISE has any further obligation for payment of the rehabilitation care. In fact, to the contrary, the complaint specifically alleges that the claims at issue in this case fall within Medicare's definition of what is a non-organization determination and thus not subject to Medicare's review provisions. [CT 228, ¶¶ 23-25.]

The complaint specifically alleges the fact that the benefits at issue in this case were ultimately provided

[CT 228, ¶ 22] and alleges the fact that MARY-LOUISE has no further obligation to pay for those benefits. [CT 228, ¶ 24.] The claims at issue, therefore, relate to non-organization determinations that are not subject to Medicare's administrative review provisions. That being the case, the trial court's sustaining of the demurrers on that ground is erroneous.

Second, Medicare's regulations only set forth the minimum benefits an HMO must provide to its Medicare enrollees and, in fact, a Medicare-qualified HMO is allowed to provide even broader benefits. (42 U.S.C. § 1395mm(c)(2)(A)(ii).)

MARY-LOUISE's contract claim is not predicated on the care she should have received under Medicare, but the care she was entitled to under the contractual promises made by FHP to provide care over and above the care she was entitled to under the bare Medicare provisions. As alleged in paragraph 27 of the First Amended Complaint, FHP promised to provide MARY-LOUISE with more than just Medicare benefits:

> For example, under the FHP plan, irrespective of the parameters for Medicare approval of home health care, FHP promises to provide all medically-necessary in-hospital rehabilitation services, irrespective of the level of benefits and irrespective of the benefit guidelines imposed by Medicare. (See Exhibit A, p. 26.) Similarly, under the FHP plan, FHP promises to provide home health care and rehabilitation services when it is medically necessary and prescribed by an FHP physician, irrespective of the Medicare parameters.

[CT 229-230, ¶ 27.]

Under Medicare regulations, in order for physical or occupational therapy to be covered, that therapy must be provided only when "there is an expectation that the patient's condition will improve significantly in a reasonably (and generally predictable) period of time." (Medicare Explained (CCH, Inc. 1997) ¶ 381, p. 112.) But FHP promises far more. Indeed, in its benefit summary, FHP promises to provide full rehabilitation services, including physical therapy and occupational therapy whenever the services are authorized by an FHP Plan Physician. [CT 235, ¶ 44.] Thus, under FHP's promised benefits, the therapy is covered even if there is no showing that the patient's condition will significantly improve within a reasonable period of time – a distinct difference from the Medicare provision.

Tellingly, MARY-LOUISE was repeatedly denied benefits by FHP because she was not improving rapidly enough – i.e., FHP was applying the Medicare standard. But FHP had an obligation to provide MARY-LOUISE with more care than Medicare promised and it was that care – the therapy over and above that mandated by Medicare – which was denied to her and which is at issue in this action. That being the case, Medicare's administrative review provisions did not apply in the first instance. As such, the appellate court's conclusion that MARY-LOUISE must exhaust Medicare's administrative remedies is patently erroneous.

CONCLUSION

The *Redmond* court misquoted the Medicare statutes, misapplied the law, ignored federal cases interpreting a federal statute and erroneously imposed a federal administrative process by refusing to honor and apply the state's tort law – even in the absence of any possible basis for federal preemption. The danger represented by the *Redmond* case has become a reality – its erroneous analysis has now been followed by another court. It can only be expected that yet other courts will also follow *Redmond* and California's growing number of senior citizens who are enrolled in Medicare HMOs are entitled to have that error in California law corrected. The instant case presents the optimal opportunity for this Court to do precisely that and it is respectfully requested that certiorari be granted.

Respectfully submitted,

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APPENDIX

APPENDIX A — OPINION OF THE STATE OF CALIFORNIA COURT OF APPEAL FOR THE FOURTH DISTRICT, DIVISION TWO DATED AND FILED FEBRUARY 5, 1999

COURT OF APPEAL, FOURTH DISTRICT
DIVISION TWO
STATE OF CALIFORNIA

E021602
(Super.Ct.No. SCV-35262)

MARY-LOUISE O'NEAL,

Plaintiff and Appellant,

v.

FHP, INC. et al.,

Defendants and Respondents.

OPINION

* * *

Plaintiff Mary-Louise O'Neal (herein "Plaintiff"), challenges the trial court's grant of a demurrer without leave to amend to her first amended complaint against defendants FHP Healthcare Corporation, Inc. (the "HMO"), Loma Linda Faculty Medical Group, Inc., Bonnie Barnes, Reche Canyon Rehabilitation and Health Care Center, and Cynthia M. Gleason (herein collectively referred to as "Defendants").

Appendix A

PROCEDURAL BACKGROUND AND FACTS[1]

In January 1995, at the age of 90, Plaintiff enrolled in the HMO's senior-care health benefits plan. One year later, she suffered a stroke. The HMO authorized her admittance to a skilled nursing facility for rehabilitation. During the course of her stay, the HMO conducted periodic evaluations of her condition. Following each evaluation, the HMO determined that Plaintiff had plateaued and recommended a transfer to a convalescent hospital. However, Plaintiff's son, Enos Doyle, refused to accept the HMO's recommendation and objected to each attempted transfer. In response to his objections, the HMO allowed Plaintiff to remain a little longer at the nursing facility.

By way of her first amended complaint, Plaintiff alleges that while she was a member of the HMO, she was not provided with rehabilitation therapy, physical therapy and skilled nursing services. On July 18, 1997, the HMO demurred to Plaintiff's first amended complaint on the grounds that Plaintiff failed to exhaust her administrative remedies. Subsequently, the other defendants joined in the demurrer.

On September 8, 1997, the trial court granted the demurrer stating, "[F]ederal law requires exhaustion of administrative remedies, . . . [¶] [t]he amended complaint

---

1. Because Plaintiff has appealed from the judgment entered following the trial court's granting Defendants' demurrer to the first amended complaint without leave to amend, we take our facts from those alleged in the amended complaint.

does not allege that plaintiff complied with the mandatory administrative provisions of the Medicare Act which was 42 U.S.C. 1395 and the applicable federal regulations . . . . [¶] . . . In this state, if a plaintiff has statutory administrative remedies available, she must pursue them before turning to the courts[.]" An order granting the demurrer and dismissing Plaintiff's action was filed on October 15, 1997. Plaintiff appealed.

STANDARD OF REVIEW

"Where a trial court sustains a demurrer without leave to amend, we review such action under the abuse of discretion standard. [Citation.] If there is a reasonable possibility that the pleading can be cured by an amendment, the trial court's ruling will be reversed. [Citation.] [¶] On review, we examine the Complaint's factual allegations to determine whether they state a cause of action on any available legal theory. [Citation.] We treat the demurrer as admitting all material facts which were properly pleaded. [Citation.] However, we will not assume the truth of contentions, deductions, or conclusions of fact or law [citation] and we may disregard any allegations that are contrary to the law or to a fact of which judicial notice may be taken. [Citation.]" (*Interinsurance Exchange* v. *Narula* (1995) 33 Cal.App.4th 1140, 1143.)

DISCUSSION

The primary issue to be decided in this appeal is whether the exclusive review provisions of Title XVIII of the federal Social Security Act, 42 United States Code section 1395

("Medicare Act"), apply. Plaintiff contends that they do not because (1) she ultimately received the rehabilitation treatment which is the basis for her claim, and (2) the benefits which she sought fell within the optional supplemental plan provision of the HMO, i.e., "she was entitled to . . . care *over and above* the care she was entitled to under the bare Medicare provisions." Defendants disagree, relying on the holding in *Redmond* v. *Secure Horizons, Pacificare, Inc.* (1997) 60 Cal.App.4th 96. We agree with Defendants.

"Federal law specifies the services which health maintenance organizations such as [the HMO] must provide to Medicare-eligible members such as [P]laintiff who are enrolled in Medicare-subsidized health care plans. (42 U.S.C. § 1395mm.) The authority to determine whether certain services are covered by such a plan has been vested by Congress in the Secretary of Health and Human Services. 'The determination of whether an individual is entitled to benefits . . . and the determination of the amount of benefits . . . , *and any other determination with respect to a claim for benefits* . . . shall be made by the Secretary [of Health and Human Services] in accordance with regulations prescribed by him.' (42 U.S.C. § 1395ff(a), italics added.) 'If the Secretary determines that an eligible organization with a contract wider this section . . . [¶] . . . fails substantially to provide medically necessary items and services that are required (under law or under the contract) . . . , if the failure has adversely affected (or has substantial likelihood of adversely affecting) the individual . . . [¶] . . . [¶] the Secretary may provide, in addition to any other remedies authorized by law, for [civil money penalties, suspension of enrollment of individuals or suspension of payment to the organization].' (42 U.S.C. § 1395mm(i)(6).)

Appendix A

"A claim which 'arises under' the Medicare Act must be brought before the Secretary through a multilevel administrative review process. This administrative review process (which was expressly set forth in the contract between plaintiff and defendant) provides the 'exclusive' remedy for such claims. (Sen.Rep. No. 404, 89th Congress, 1st Sess., (1965) reprinted in 1965 U.S. Code Cong. & Admin. News, at p. 1995.) *Judicial* review of such claims is available only after the claimant has pressed the claim through every level of the administrative review process to a 'final' decision by the Secretary and even then such review may only be obtained in *federal* court. (*Heckler* v. *Ringer* (1984) 466 U.S. 602, 605-606 . . . .) It follows that such claims are never within the jurisdiction of a state court." (*Redmond* v. *Secure Horizons Pacificare, Inc.*, *supra*, 60 Cal.App.4th 96, 100-101, original emphasis.)

In *Redmond*, plaintiff brought a bad faith action against her health maintenance organization based on its initial denial of coverage and subsequent delayed payment of her claim for reimbursement of health care expenses covered under her Medicare-subsidized agreement with it. The trial court found that it lacked subject matter jurisdiction, sustained defendant's demurrer without leave to amend, and entered judgment of dismissal. Plaintiff appealed and the appellate court affirmed. The appellate court found that plaintiff's causes of action were claims arising under the Medicare Act, and had to be brought through a multilevel administrative review process that provides the exclusive remedy for such claims. Further, judicial review could only be obtained in federal court.

Here, as in *Redmond*, the trial court concluded that it lacked jurisdiction to hear Plaintiff's claims because they arose under the Medicare Act. Plaintiff maintains that the trial court was wrong because (1) her claims are not ones for benefits but for the injuries she suffered as a result of the HMO's repeated reluctance to provide rehabilitation treatment, and (2) her claims are based on her contract with the HMO to provide services over and above those required by Medicare.

As the *Redmond* court observed, "the fact that [P]laintiff's causes of action are based on her contractual relationship with [the HMO] does not mean that her claims did not arise under the Medicare Act." (*Redmond* v. *Secure Horizons, Pacificare, Inc., supra*, 60 Cal.App.4th 96, 101.) First, we note that Plaintiff's contract with the HMO specifically discusses the procedures to be followed when Plaintiff has a "dispute, complaint or question related to the provision of services" of her benefit plan. Included in the discussion is the reference to the review provisions of the Medicare Act. Second, although Plaintiff chooses to characterize her complaints as contractually based causes of actions, the fact remains that they are, by necessity, complaints regarding the HMO's initial refusal to provide services. She complains that the HMO initially wrongfully refused to provide her with additional skilled nursing and rehabilitation services, and then only agreed to provide such services after her son objected to its decision. Under the contract, such claims must be resolved under the administrative review process specified in the Medicare Act and therefore these claims arise under the Medicare Act.

Next, while Plaintiff's claims are not actually claims for benefits, because she ultimately received the services, her claims "*are* 'inextricably intertwined' with a claim that she was entitled to [the services] she received." (*Redmond* v. *Secure Horizons, Pacificare, Inc.*, *supra*, 60 Cal.App.4th 96, 102, original emphasis.) Like the plaintiff in the *Redmond* case, Plaintiff argues that her complaint is based on the HMO's conduct with respect to her claim for services. However, "[t]his argument fails because the alleged wrongfulness of [the HMO's] conduct depends on whether [P]laintiff was entitled to [the services received.] The fact that [the HMO] ultimately [provided such services to her] does not necessarily establish that [she] was *entitled* to such [services.]" (*Ibid.*, original emphasis; see *Heckler* v. *Ringer* (1984) 466 U.S. 602, 615-619 [It is of no importance that plaintiffs sought only declaratory and injunctive relief and not an actual award of benefits; their claims were essentially claims for benefits subject to the requirement that they exhaust the administrative review procedures.].) Moreover, as the Redmond court stated, "The administrative review process applies not only to coverage determinations but also to 'any other determination *with respect* to a claim for benefits,' and the Secretary is authorized to order civil money penalties or 'any other remedies authorized by law' if an organization such as defendant fails to provide required services." (*Redmond* v. *Secure Horizons, Pacificare, Inc.*, *supra*, 60 Cal.App.4th 96, 103, original emphasis.)

We also reject Plaintiff's argument that her claims are based on her contract with the HMO to provide services over and above those required by Medicare and thus, outside the provisions of the Medicare Act. As Defendants point out,

this argument ignores the clear language in Plaintiff's contract, "PLAN COVERS ALL SERVICES. YOU PAY Nothing for up to 100 days per Benefit Period for as long as daily skilled nursing care is determined to be medically necessary by your Primary Care Physician *in accordance with Medicare guidelines*." Similarly, the applicability of the Medicare guidelines to all services under the contract is confirmed in the exclusions and limitations portion of the policy which denies coverage for "[a]ll services and items not reasonable and necessary for the diagnosis and treatment of illness or injury as determined by an FHP Plan Physician, *using Medicare guidelines* relying upon professionally recognized standards of practice except as specifically stated elsewhere in your Evidence of Coverage and Disclosure Form."

Further, we note that the language in the Medicare Act authorizes the Secretary to take the necessary action when a health maintenance organization fails to provide medically necessary items and services required under law or under the contract. "If the Secretary determines that an eligible organization with a contract under this section — [¶] (i) fails substantially to provide medically necessary items and services that are required (under law *or under the contract*) to be provided to an individual covered under the contract, if the failure has adversely affected . . . the individual . . . [¶] the Secretary may provide, in addition to any other remedies authorized by law, for any of the remedies described in subparagraph (B)." (42 U.S.C. § 1395mm(i)(6)(A), emphasis added.)

Nonetheless, Plaintiff relies on the Ninth Circuit Court of Appeals' decision in *Ardary* v. *Aetna Health Plans of*

California, Inc. (9th Cir. 1996) 98 F.3d 496 and argues that her tort claims are not subject to Medicare's exclusive review provisions. In *Ardary*, the court held that a wrongful death cause of action arising from an organization's denial of Medicare benefits could be brought in state court and did not require exhaustion of the Act's administrative review process because the action was not based on the Medicare Act and did not seek to recover benefits. We reject Plaintiff's argument for two reasons. First, we are not bound by decisions of the federal circuit courts of appeal on federal constitutional questions, even those decisions from our own Ninth Circuit. (*Debtor Reorganizers, Inc.* v. *State Bd. of Equalization* (1976) 58 Cal.App.3d 691, 696; *Alicia T.* v. *County of Los Angeles* (1990) 222 Cal.App.3d 869, 879.) Second, this same argument was made and rejected in the *Redmond* case. We agree with the *Redmond* court's analysis and find the *Ardary* decision equally inapplicable to the facts of this case. (*Redmond* v. *Secure Horizons, Pacificare, Inc.*, *supra*, 60 Cal.App.4th 96, 103-104.)

Likewise, we find Plaintiff's reliance on the decision in *Solorzano* v. *Superior Court* (1992) 10 Cal.App.4th 1135 misplaced. The *Solorzano* case involved the issue of whether individual states could regulate the marketing practices of HMO's when dealing with Medicare beneficiaries. Concluding that federal law did not preempt the states from doing so, the *Solorzano* court stated, "Congress clearly recognized the need for state and local assistance in regulating the marketing of HMO's and other supplemental health care packages to the elderly and disabled and, quite the opposite of intending preemption, appears to have intended a call to the states (and private parties) for all the

help it can get." (*Id.*, at p. 1149.) The ruling in *Solorzano* does not apply to the determination of covered benefits under an HMO insurance plan or Medicare. Instead, it is limited to state regulation of HMOs' marketing practices.

Finally, Plaintiff contends that the HMO's failure to timely notify her of her right to review its benefit decisions precludes it from now asserting those provisions. She cites four cases: *Davis* v. *Blue Cross of Northern California* (1979) 25 Cal.3d 418, *Sarchett* v. *Blue Shield of California* (1987) 43 Cal.3d 1, *Chase* v. *Blue Cross of California* (1996) 42 Cal.App.4th 1142, and *Waller* v. *Truck Ins. Exchange, Inc.* (1995) 11 Cal.4th 1. As Defendants point out, these cases are inapplicable because they involve the application of a contractual arbitration provision. Each case held that a contractual arbitration provision was only enforceable where the arbitration provision was clearly and conspicuously set forth in the contract of insurance, and the insurer notified the insured of the arbitration provision at the time that the insured contested a claims determination. Here, individual healthcare providers cannot waive the requirement that the members participate in the federally mandated administrative review process set forth in the Medicare Act. (*Heckler* v. *Ringer*, *supra*, 466 U.S. 602, 617; *Matthews* v. *Eldridge* (1976) 424 U.S. 319, 328.) Accordingly, we disagree with Plaintiff's contention.

DISPOSITION

The judgment is affirmed. Respondents are to recover their costs on appeal.

Appendix A

NOT FOR PUBLICATION

s/ HOLLENHORST
Acting P.J.

We concur:

s/ RICHLI
J.

s/ WARD
J.

APPENDIX B — NOTICE OF ENTRY OF JUDGMENT DATED DECEMBER 5, 1997 AND FILED DECEMBER 9, 1997

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Attorney for Defendants, FHP, INC.,
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SUPERIOR COURT OF THE STATE OF CALIFORNIA FOR THE COUNTY OF SAN BERNARDINO

Case No. SCV 35262

MARY LOUISE O'NEAL,

Plaintiff,

v.

FHP HEALTHCARE CORPORATION, LOMA LINDA FACULTY MEDICAL GROUP, INC., BONNIE BARNES, RECHE CANYON REHABILITATION AND CARE CENTER, CYNTHIA M. GLEASON, AND DOES 1- 100, INCLUSIVE,

Defendants.

NOTICE OF ENTRY OF JUDGMENT

Appendix B

TO ALL PARTIES AND TO THEIR ATTORNEYS OR RECORD HEREIN:

NOTICE IS HEREBY GIVEN that the Honorable John P. Wade sitting in Department 11 of the above-entitled Court, signed an Order for Dismissal of this action on October 15, 1997. Pursuant to *Code of Civil Procedure* Section 581(d), judgment was entered at that time. A conformed copy of Judge Wade's Order is attached to this Notice.

Dated: December 5, 1997 KONOWIECKI & RANK

By: s/ Thomas C. Knego
Thomas C. Knego
Attorney for Defendants,
FHP, INC.

Appendix B

KONOWIECKI & RANK
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Attorneys for Defendant,
FHP, INC., incorrectly named as FHP HEALTHCARE CORPORATION

SUPERIOR COURT OF THE STATE OF CALIFORNIA FOR THE COUNTY OF SAN BERNARDINO

CASE NO. SCV 35262

MARY-LOUISE O'NEAL,

Plaintiff,

vs.

FHP HEALTHCARE CORPORATION, LOMA LINDA FACULTY MEDICAL GROUP, INC., BONNIES BARNES, RECHE CANYON REHABILITATION AND HEALTH CARE CENTER, CYNTHIA M. GLEASON, AND DOES 1-100, INCLUSIVE,

Defendants.

ORDER ON DEFENDANT FHP, INC.'S DEMURRER TO PLAINTIFF'S FIRST AMENDED COMPLAINT

Appendix B

Date: September 8, 1997
Time: 8:30 a.m.
Dept.: 11

Trial Date: None

TO ALL PARTIES AND TO THEIR ATTORNEYS OF RECORD:

The Demurrer to Plaintiff's First Amended Complaint brought by Defendant, FHP, INC. and joined in by defendants RECHE CANYON REHABILITATION AND HEALTH CARE CENTER and CYNTHIA M. GLEASON, as well as defendants, LOMA LINDA FACULTY MEDICAL GROUP, INC. and BONNIE BARNES, came on regularly for hearing at 8:30 a.m. in Department 11 of the above-entitled court on September 8, 1997, the Honorable John P. Wade, Presiding.

Plaintiff appeared by her attorney, Jolene Yorba, of Shernoff, Bidart, Darras and Arvin; defendant, FHP, INC. appeared by its attorney, Lynn E. Iba of Konowiecki & Rank; defendants, RECHE CANYON REHABILITATION AND HEALTH CARE CENTER, INC. and CYNTHIA M. GLEASON, appeared by their attorney, Kevin E. McCann of McCann and Carroll; and defendants, LOMA LINDA FACULTY MEDICAL GROUP, INC., and BONNIE BARNES, appeared by their attorney, Christopher Cannon, of La Follette, Johnson, De Haas, Fesler and Ames.

Upon full reconsideration of all points and authorities filed in support of and in opposition to the demurrer, and following oral argument, the court sustained all demurrers without leave to amend.

Appendix B

It is hereby ordered, adjudged and decreed, that the defendants' demurrer to plaintiff's first amended complaint is sustained without leave to amend;

It is further ordered, adjudged and decreed that the plaintiff's First Amended Complaint is therefore dismissed in its entirety.

IT IS SO ORDERED.

Dated: 10-15-, 1997

By: s/ JOHN P. WADE
John P. Wade
JUDGE OF THE SUPERIOR COURT

APPENDIX C — ORDER OF THE SUPREME COURT OF CALIFORNIA FOR THE FOURTH APPELLATE DISTRICT, DIVISION TWO DENYING PETITION FOR REVIEW DATED AND FILED APRIL 28, 1999

Fourth Appellate District, Division Two, No. E021602
S077316
IN THE SUPREME COURT OF CALIFORNIA

MARY-LOUISE O'NEAL,

Appellant

v.

FHP INC. Et Al.,

Respondents

Appellant's petition for review DENIED.

The request for an order directing publication of the opinion is DENIED.

s/ George
Chief Justice